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Original Communication

Aggression and violence towards health care providers – A problem in Turkey? ☆

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Abstract

Health care providers are increasingly concerned about the escalating incidence of verbal and physical abuse to healthcare staff. Factors, such as long wait in hospital areas, which lead to client frustration over an inability to obtain needed services promptly, are influencing these situations. Nonetheless, incidents of this nature can cause immense psychological harm as well as physical damage among medical employees.

The current study aimed to ascertain from staff members aggressive experiences in the workplace, and the effects on the individual. The results of this study mirrored those of similar surveys in Turkey. Non-reporting was revealed as a major problem. Respondents believed they were treated less seriously than similar incidents involving private citizens. Accordingly, staff criticized hospital managers, the police, and the courts for their attitude about assaults towards hospital employees. They reported feeling vulnerable to abuse and there was a general desire for training in preventing and protection. These include teaching staff breakaway techniques, increasing the number of trained security officers on duty, issuing personal alarms, and encouraging staff to officially report all incidents.

Keywords: Aggression; Violence; Health care providers; Workplace; Emergency department

1. Introduction

Health reports provide an overview of the health of a country's population and the main factors related to it. Based on international comparisons, they present a summary assessment of what has been achieved so far and what could be improved in the future. A special case of comparison is when each hospital is given a rank order. Although useful as summary measures, ranks can be misleading and should be interpreted with caution. Also, when used to give an assessment of trends, ranks can hide quite important changes within an individual hospital.[1–5]

Based on information through mediums such as the Internet, the expectation of patients and their relatives is therefore extremely high, or on the contrary apprehensive, when expecting, wanting, or requiring treatment.[6] This attitude can easily change into anger, rage, or violence facing realities of clinical practice in emergency departments.[7] Factors, such as long wait in hospital environments, which lead to client frustration over an inability to obtain needed services promptly, are influencing these situations.[8] Nonetheless, incidents of this nature can inflict immense psychological harm as well as physical damage among medical employees.[9] How serious or otherwise this is treated by the victim very much depends on the circumstances and

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the assailant.[10] The current study aimed to ascertain from health care employees aggressive and violent experiences in the workplace, and the effects on the individual. Recommendations are made to increase the awareness of aggressive behavior by setting policies and appropriate, regularly updated training for all health care providers.

2. Materials and methods

For the purpose of this study, a 15-item questionnaire was designed and confidentially offered to physicians, nurses/midwives, and attendants, in emergency departments. Attendants are patient care assistants with handling and lifting duties. The detailed survey regarding aggressive and violent behavior was conducted at the University Hospital, the State Hospital, the Hospital of Gynecology and Pediatrics, and at the Health Clinic, in the province of Bolu, Turkey, over a 5-year period (1998–2003). The hospital's catchments area is largely urban working class and includes many communities, according to their different socio-economic levels. The aims of the survey included determining the following factors: what proportion of staff had experienced or witnessed verbal or physical violence, whether age and experience sufficed to cope with an aggressive behavior, their perception of severity, associated degree of stress, whether the violence was officially reported, and the level of staff training in dealing with violence. Some of the findings are displayed in the form of tables.

3. Results

From staff members approached, a total of 124 responded to the questionnaire: 62 physicians (50.0%), 44 nurses/midwives (35.48%), and 18 attendants (14.52%). Divided into the category of gender: 79 male (63.7%) and 45 female (36.3%) respondents. Table 1 presents the total numbers and percentage of respondents among different professions, who reported encountering aggressive incidents in their workplace. These findings indicate, that physicians (96.77%) and nurses/midwives (81.82%) have a consistently high level of exposure. A total of 108 (87.1%) out of 124 staff members experienced aggressive behavior.

An approach to compare age groups, respondents were divided into five age intervals: $\leqslant 20$ ($n = 1$), 21–30 ($n = 67$), 31–40 ($n = 43$), 41–50 ($n = 11$), and $\geqslant 51$ ($n = 2$). According to the low numbers of the first and last age interval, respondents were shift to the next/reverse age group. The variations are seen as followed: in the 21–30-age group 68 staff members and 13 in the 41–50-age group. The vast majority of the respondents were represented in the second [$n = 68$ (54.84%)] and third [$n = 43$ (34.67%)] age interval. Whereas the statistical results, regarding age intervals, and between male and female respondents, who reported encountering aggressive incidents, are presented in Table 2.

Based on international literature,[11,12] three categories of aggressive behavior were presented and participants were required to indicate if they had experienced and/or witnessed single or multiple sources of violence within 5 years, as indicated in Table 3. Unfortunately, the current perceived level of verbal abuse (total of 46.98%) and threatening behavior (total of 33.56%) seems to be frequent in emergency departments. Accordingly, the data were also examined for experience earned in practice on how to deal with threat of violence, abusive behavior, and physical assault. To facilitate comparisons among experience, respondents were divided into four groups. The length of health service career ranged from under 5 years up to more than 15 years: $\leqslant 5$ ($n = 39$), 6–10 ($n = 39$), 11–15 ($n = 21$), and $\geqslant 15$ ($n = 25$). In the first group 89.74%, in the second 94.87%, in the third 80.95%, and in the last group 92.0% of the respondent's encountered aggressive behavior, respectively. Considerably, there were no substantial differences regarding encountering aggressive behavior between each group. The only statistically significant difference that emerged from the research was in relation to the extent of trauma due to aggressive and violent incidents among health care providers, seen in Table 4. Whereas no trau-

Table 1
Respondents among different professions in the emergency departments reporting experiences of aggression over a five-year period ($n = 124$)

	Experience of aggressive behavior (n)	Non-experience of aggressive behavior (n)	Total (n)
Statistical results among profession			
Physician	60 (96.77%)	2 (3.23%)	62 (100.0%)
Nurse/Midwife	36 (81.82%)	8 (18.18%)	44 (100.0%)
Attendant	12 (66.67%)	6 (33.33%)	18 (100.0%)
Total (n)	108 (87.1%)	16 (12.9%)	124 (100.0%)

Table 2
Statistical results regarding age groups, and between male and female respondents, who reported encountering aggressive incidents (male $n = 79$; female $n = 45$)

Age interval	Experience of aggressive behavior (n)			
	Male ($n = 79$)	Total male (n)	Female ($n = 45$)	Total female (n)
Statistical results of valid response				
21–30	35 (81.4%)	43 (100.0%)	20 (80.0%)	25 (100.0%)
31–40	24 (85.72%)	28 (100.0%)	11 (73.33%)	15 (100.0%)
41–50	4 (50.0%)	8 (100.0%)	4 (80.0%)	5 (100.0%)
Total (n)	63 (79.75%)	79 (100.0%)	35 (77.78%)	45 (100.0%)

Table 3
Experiencing and/or witnessing single or multiple sources of aggressive/violent incidents in the emergency departments over a five-year period ($n = 298$)

	Verbal abuse (n)	Threatening behavior (n)	Physical assault (n)	Total (n)
Statistical results of valid response				
Experience of	72 (50.7%)	48 (33.8%)	22 (15.5%)	142 (100.0%)
Witness of	68 (43.59%)	52 (33.33%)	36 (23.08%)	156 (100.0%)
Total (n)	140 (46.98%)	100 (33.56%)	58 (19.46%)	298 (100.0%)
Category of aggressive/violent incidents ($n = 304$)				
Verbal abuse (n)				
Screaming/shouting				88 (28.95%)
Calling of names/swearing				62 (20.39%)
Verbal threats				62 (20.39%)
Threatening behavior (n)				
Rising fists				56 (18.42%)
Physical assault (n)				
Slapping/kicking/grabbing				28 (9.21%)
Use of blunt force/sharp objects				6 (1.98%)
Use of weapon				2 (0.66%)
Total (n)				304 (100.0%)

matic reactions shown in the majority (42.65%) of the respondents 38.24% admitted to psychological problems ever since.

Incidents took place in hospital environments, like examination and treatment rooms (39.28%) and waiting rooms of the emergency departments (36.9%), followed by triage (11.9%), and arenas (10.71%). The respondents indicated that dissatisfaction with waiting/care time (57.2%) has been causally implicated in violent incidents. Furthermore, a related factor was alcohol abuse and illicit drug use (25.7%), and economic problems (17.1%).

Of equal interest is the fact that, in spite of the frequency of violent incidents (87.1%), verbal abuse and threatening behavior was never or rarely reported officially (75.73%). Emphasis on reporting such incidents (22.33%) appeared to involve physical violence. Nevertheless, adequate different types of systems, concerning evidence and reducing the risk of violence, are missing in the majority (28.57%), respectively. During a violent incident, the respondents sought support mainly from un-trained security officers (41.67%), and from attendants (25.0%). It is also a matter of concern, that only 4 (3.23%) respondents in this study indicated, that they had training in the management of aggression and violence. Accordingly, 114 respondents (91.93%) expressed a desire for specialized training to cope with violent incidents.

Table 4
Extent of trauma due to aggressive/violent incidents among health care providers ($n = 136$)

Statistical results of valid response	
Non-traumatic reaction	58 (42.65%)
Psychological trauma	52 (38.24%)
Minor trauma	20 (14.71%)
Life-threatening injuries	6 (4.40%)
Total	136 (100.0%)

Table 5
Short profile of assailants (n)

Demographic statistical results of valid response	
Gender ($n = 137$)	
Male	107 (78.1%)
Female	30 (21.9%)
Total	137 (100.0%)
Assailant ($n = 124$)	
Patient	8 (6.45%)
Relative	80 (64.52%)
Patient and relative	36 (29.03)
Total	124 (100.0%)
Age (years) ($n = 146$)	
$\leqslant 20$	4 (2.74%)
21–30	76 (52.05%)
31–50	60 (41.1%)
$\geqslant 50$	6 (4.11%)
Total	146 (100.0%)
Education ($n = 186$)	
Analphabet	40 (21.51%)
Primary School	78 (41.94%)
Grammar School	40 (21.51%)
University	28 (15.04%)
Total	186 (100.0%)

There is evidence, that health care providers are likely to encounter aggressive behavior from relatives, than from patients themselves; Table 5 presents a short profile of assailants. Contrary to expectation, the aggressors cannot be identified to a certain kind of type, such as age and education, but can be directed to gender (male = 78.1%).

4. Discussion

Abusive behavior, threat of violence, and physical assault are common in the health care sector, and appear

to be of a greater problem for certain social and healthcare staff than for comparable professions.[13–15] Nevertheless, there is evidence, that physicians[16] and nurses[17,18] are more likely to encounter aggressive behavior (Table 1) – in particular by men (Table 5).[7,19] In general, more than three fourths of the represented (87.1%) staff members in this study encountered aggressive incidents in their workplace (Table 3), respectively. Such high levels of verbal aggression (total of 46.98%) and threatening behavior (33.56%) indicate, that is has become a normalized feature of this type of environment. Anecdotal evidence and other research suggest that less experienced health care providers are more likely to be victims of violence.[20–22] Considerable, the present study produced no evidence to support this suggestion. Furthermore, there were no substantial differences between age intervals, and between male and female staff members (Table 2). In addition, recognizing the serious immediate and future long-term implications for health, psychological and social development that violence represents for individuals, families, communities, and countries is of importance.[10] The extent of trauma due to violence among staff members in the workplace evaluated in this research can be seen in Table 4.

The primary responsibility is, therefore, to prevent aggressive behavior in health care settings,[23–25] as the majority of respondents indicated, that dissatisfaction with waiting/care time (57.2%) has been causally implicated in violent incidents, and the location of these occurrences have most been taken place in examination/treatment rooms (39.28%) and waiting rooms (36.9%).

According to Ayrancı et al., ''in a developing nation such as Turkey with an aggregate health setting occupancy rate of nearly 100%, such issues as lack of beds, overcrowding, patient backups, not being in control of the situation, not having a national health system, use of the emergency department, or secondary health settings, skimpy funding of primary, secondary, or tertiary health care services, and insufficient staffing, would seem to encourage violence''.[12] Nevertheless, violence in health care settings has its roots not in culture or in different systems of health care.[26,27] Employers in the health care sector have a duty to provide adequate safety measures and training to reduce risks and ensure, where possible, the health, safety, and welfare of their staff members. Respondents in this survey perceived the response of hospital management and the legal system as inadequate, yet there is growing consensus that violent experiences in the workplace are significantly under-reported (75.73%).[11,28] Factors influencing the low levels of reporting are: believing management will not support staff, that oneself is to blame, that you will be seen as incompetent, and the believe that verbal abuse and threats are part of the job.[23]

But, violence and aggressive behavior are not just a criminal justice problem[13] or just one involving aberrant behavior attributable to alcohol, drugs, respectively presented with 25.7%, or mental illness, most violent incidents within the hospital setting contain an intentional and, therefore, aggressive element, but it is often predictable and preventable.[29–31] Aggressive interactions involve interpersonal-communication and in some incidents staff projecting themselves negatively may consciously or unconsciously inflame and worsen difficult situations. The personal safety is the most important factor; minimizing client provocation will, without doubt, reduce one's risk of being assaulted in the emergency department.[28] Accordingly, 114 respondents (91.93%) expressed a desire for specialized training to cope with violent incidents. Even at the current perceived level of aggression most staff members are conscious that they lack many of the communication skills necessary to defuse a potentially violent situation.[32] Security and workshops on violence prevention strategies were felt to be the most useful potential interventions.[33–35]

This was a small study in hospital settings in Bolu, but the response generally echoed evidence from other published literature in Turkey.[36–38] This current study is limited to the fact, that hospital settings are not offering a *Violence Incident Report Form*[20,39], a list designed to simplify the registration of violent events. It contributes to definitional difficulties as well as problems in comparing research findings and using such findings to make work environments safe. Obviously, quantitative research is warranted to determine how widespread or frequent the problem actually is in Turkey. Within this context, the number of articles examining factors related to aggression and violence in hospital settings have increased,[12,40,41] but so far, it is also evident from this research that it is a serious problem, and it is not something to be lightly dismissed. And fairly clear views about what needs to be done did emerge from this research.

5. Conclusion

The general concept of aggression and violence towards health care providers has become increasingly complex and high profile within the health system. Incidents, which had an impact on the safety and welfare of individuals, tend to be either endured or dealt with directly by the victims, or managed by the powers that be with their own dynastic aims in mind, a situation that is often largely true within the culture of Turkey. However, within modern society steps must be taken to eliminate risk in all its manifestations to access control. Consequently, managers, the organization as a whole, and the governmental authority must take violence, threat, and verbal abuse against staff members seriously, and should consult independent respected professionals in order to make risk assessments. A clear definition of violence, which takes into account severity, perceptions, and professional discretion in reporting and dealing with incidents, and counseling for affected staff members are relevant. The risk management process should also enable the optimum level of care to be given to a client and their relatives, and involves the assessment of risk relating to patient care, care systems, and the environment of care. A balance needs to be struck between

maintaining patients' rights and protecting potential victims of violent behavior. An 'ethical perspective' in drawing up any legislation to deal with this issue would undoubtedly offer a more collaborative and balanced view in this respect. In order to address this theme adequately the necessary resources, such as federal guidelines for a *Violence Incident Report Form*, data collection, analysis, and interpretation, will have to be established and have to be made available to recruit, train, and supervise medical staff and working security devices, as well as to provide enough staff members to cope with increased demand, especially in the emergency departments. Recognition of impending trouble, communication skills to defuse trouble, physical training in situations where reporting has identified that physical violence is a problem, provision of physical skills training with the skills that staff actually need, monitoring the effectiveness of training through on-going reporting, pursuit of litigation against aggressors, working agreement with police and security, protocols in place for the management of acutely disturbed patients to include rapid tranquillization is essential. Finally, attention needs to be paid to public education by using the influence of reporting by the media, and focus public opinion into one of demanding change from the national initiatives and by medical health services management. No doubt, it will be useful and necessary to look at strategies from other parts of the world,[42–51] which aim to deal with the problem.

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